

318

1003

1344

-61-006920

STATE FILE NUMBER

AMENDED

Registration District No. 318
FILED VS FEB 20 1961

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived... If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		Length of stay in 1b Life Time		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2659 Lucas Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GENA MARIE SMITH</u>				4. DATE OF DEATH Month Day Year <u>FEB. 8, 1961</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-1958</u>		
9. AGE (last birthday) <u>2</u>		IF UNDER 1 YEAR Months Days <u>4 26</u>		IF UNDER 24 HR Hours Min. <u>4 26</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>								
13a. FATHER'S NAME <u>Leonard T. Smith</u>				13b. MOTHER'S MAIDEN NAME <u>Era Mae Whitfield</u>		14. NAME OF HUSBAND OR WIFE <u>-</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Leonard T. Smith</u> Address <u>2659 Lucas Ave.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Tracheobronchial aspiration</u> DUE TO (c) <u>491x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Microcephaly - Cerebral Palsy</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>2/3/61</u> to <u>2/8/61</u> and last saw her alive on <u>2/8/61</u> Death occurred at <u>12:05 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Wilma Osborn, M.D.</u>				22b. ADDRESS <u>1515 LAFAYETTE AVE</u>		22c. DATE SIGNED <u>2/8/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2-13-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>J. H. RANDLE & SON 3133 Bell Ave.</u>				25. DATE RECD. BY LOCAL REG. <u>FEB 10 1961</u>		26. REGISTRAR'S SIGNATURE <u>Leon Smith, M.D.</u>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. 1. SHOULD READ

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Esther K. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Wash

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.